Medicare Part D Opt-In Form

When you become eligible for Medicare, you must enroll in Medicare Part A and/or Medicare Part B in order to continue to receive prescription drug coverage through the Cincinnati Retirement System (CRS). When you provide a copy of your Medicare Health Insurance Card to CRS, you will automatically be enrolled in UnitedHealthcare® MedicareRx for Groups (PDP), a Medicare Part D prescription drug plan.

Please check the box, fill in the information and sign below to opt into the CRS prescription drug coverage from UnitedHealthcare MedicareRx.

☐ I choose to continue to receive CRS prescription drug coverage. I understand I am eligible to receive prescription drug coverage through CRS because I am enrolled in retiree healthcare coverage through CRS. I understand that monthly premium payments for CRS retiree healthcare coverage will continue to be automatically deducted from the pensioner's monthly retiree benefit payment. I understand that CRS will automatically enroll me in Medicare Part D prescription drug coverage after I am eligible for Medicare Part A and/or enroll in Medicare Part B and send a copy of my Medicare Health Insurance Card to CRS with this form.

I understand that if my enrollment in the Medicare Part D prescription drug plan cannot be processed, OR if I am later disenrolled from the UnitedHealthcare® MedicareRx for Groups (PDP) Medicare Part D prescription drug plan, I will lose my CRS prescription drug coverage. If I am the retiree, I also understand that my covered spouse and dependent(s) will also lose their prescription drug coverage provided through CRS.

By agreeing to be enrolled in a Medicare Part D plan, I acknowledge that UnitedHealthcare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information provided on this form is correct to the best of my knowledge. I understand that I may be disenrolled from the plan if I intentionally provide false information as part of my enrollment.

Enrollee Name (first/last please print)	Social Security Number	Relationship to CRS Pensioner
Pensioner Name (first/last – please print)	Social Security Number	

Enrollee Medicare Claim Number (from red, white & blue card)	Effective Date: Part A	Effective Date: Part B	Phone Number

Permanent Residence/Long-term Care Facility Street Address (Medicare does not allow a P.O. Box)		
City	State	ZIP Code

Signature of Pensioner or Spouse/Dependent who is becoming eligible for Medicare **SIGNATURE DATE**

☐ Please check here if the person signing this form is the authorized representative for the Pensioner, Spouse or Dependent.

Name of Authorized Representative (first/last – please print)	Phone Number

Address	City	State	ZIP Code

Relationship to Pensioner, Spouse or Dependent:

☐ Child ☐ Spouse ☐ Friend Other (please specify) _____

Please return this form at least 30 days before your Coverage Effective Date via fax to (513) 352-1520 or mail to 801 Plum St., Suite 240 Cincinnati, Ohio 45202